



## STATE OF ILLINOIS

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Facility Name & ID Number Selfhelp Home of Chicago# 0018580 Report Period Beginning: 10/01/00 Ending: 9/30/01

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>30</u>	Skilled (SNF)	<u>30</u>	<u>10,950</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>35</u>	Intermediate (ICF)	<u>35</u>	<u>12,775</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>65</u>	TOTALS	<u>65</u>	<u>23,725</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>992</u>	<u>5,100</u>		<u>6,092</u>	8
9	SNF/PED					9
10	ICF	<u>3,114</u>	<u>11,543</u>		<u>14,657</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,106</u>	<u>16,643</u>		<u>20,749</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 87.46%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒ NO ☐ Non-allowable costs have been  
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/57

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date N/A NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified 0 and days of care provided N/AMedicare Intermediary N/A

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 9/30/2001 Fiscal Year: 9/30/2001

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning: 10/01/00

Ending: 9/30/01

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	251,430		11,060	262,490		262,490		262,490			1
2	Food Purchase		193,835		193,835		193,835	(5,057)	188,778			2
3	Housekeeping	94,512	20,424		114,936		114,936		114,936			3
4	Laundry		28,964		28,964		28,964		28,964			4
5	Heat and Other Utilities			68,489	68,489		68,489		68,489			5
6	Maintenance	50,607		52,676	103,283		103,283	38,904	142,187			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	396,549	243,223	132,225	771,997		771,997	33,847	805,844			8
	<b>B. Health Care and Programs</b>											
9	Medical Director											9
10	Nursing and Medical Records	1,127,438	85,699	4,736	1,217,873		1,217,873		1,217,873			10
10a	Therapy											10a
11	Activities	75,184	10,636	2,241	88,061		88,061		88,061			11
12	Social Services			1,674	1,674		1,674		1,674			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,202,622	96,335	8,651	1,307,608		1,307,608		1,307,608			16
	<b>C. General Administration</b>											
17	Administrative	97,412			97,412		97,412		97,412			17
18	Directors Fees											18
19	Professional Services			31,588	31,588		31,588		31,588			19
20	Dues, Fees, Subscriptions & Promotions			7,114	7,114		7,114		7,114			20
21	Clerical & General Office Expenses	154,349	7,877	27,822	190,048		190,048	(8,143)	181,905			21
22	Employee Benefits & Payroll Taxes			309,620	309,620		309,620		309,620			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,160	1,160		1,160		1,160			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	251,761	7,877	377,304	636,942		636,942	(8,143)	628,799			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,850,932	347,435	518,180	2,716,547		2,716,547	25,704	2,742,251			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			67,498	67,498		67,498	26,387	93,885			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			54,180	54,180		54,180	(54,180)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			121,678	121,678		121,678	(27,793)	93,885			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		258		258		258		258			41
42	Provider Participation Fee			35,587	35,587		35,587		35,587			42
43	Other (specify):* <b>Nonallowable costs</b>	7,186		30,353	37,539		37,539	(37,539)				43
44	<b>TOTAL Special Cost Centers</b>	7,186	258	65,940	73,384		73,384	(37,539)	35,845			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,858,118	347,693	705,798	2,911,609		2,911,609	(39,628)	2,871,981			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report

SEE ACCOUNTANTS' COMPILATION REPORT

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
<b>NON-ALLOWABLE EXPENSES</b>				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(5,057)	2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(65,123)	30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(16,450)	43		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Sch 5a	(29,232)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (115,862)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	76,234		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 76,234		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (39,628)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.

PROVIDER # 0018580

September 30, 2001

**Schedule 5A**

**VI. ADJUSTMENT DETAIL**

**NON-ALLOWABLE EXPENSES**

**LINE 29 - Other**

Description	Amount	Schedule V
		Reference
Disallow Outreach Program	(176)	43
Disallow Gift Shop Purchases	(10,308)	43
Disallow Special Needs	(182)	43
Disallow Marketing Salaries	(7,186)	43
Disallow Art Show	(2,887)	43
Disallow Web Site	(350)	43
Miscellaneous Income Offset	(8,143)	21
<b>Total</b>	<b><u>(29,232)</u></b>	

**See Accountants' Compilation Report**

Selfhelp Home of Chicago

ID# 0018580

Report Period Beginning: 10/01/00

Ending: 9/30/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

**9/30/01**

**9/30/01**

[illegible]

## Summary B

9/30/01

[illegible]

Facility Name & ID Number Selfhelp Home of Chicago# 0018580Report Period Beginning: 10/01/00Ending: 9/30/01

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				The Selfhelp Home, Inc.-Center Division	Chicago	Lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 Maintenance	\$	The Selfhelp Home Inc.-Center Division	0.00%	\$ 38,904	\$ 38,904	1
2	V	30 Depreciation		The Selfhelp Home Inc.-Center Division	0.00%	91,510	91,510	2
3	V	34 Rent	54,180	The Selfhelp Home Inc.-Center Division	0.00%		(54,180)	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 54,180			\$ 130,414	\$ * 76,234	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago # 0018580 Report Period Beginning: 10/01/00 Ending: 9/30/01

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	See Attached Schedule 7A										3
4											4
5			No compensation or fees were paid to the Board of Directors								5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.

PROVIDER # 0018580

September 30, 2001

**Schedule 7A**

<b>Name</b>	<b>Title</b>	<b>Function</b>
Herbert Roth	President	Board Member
Rolf Weil	Imm. Past President	Board Member
Gerald Franks	First Vice-President	Board Member
Bernard Baum	Vice President	Board Member
Austin Hirsch	Vice President	Board Member
Leni Weil	Treasurer	Board Member
Steven Loewenthal	Assistant Treasurer	Board Member
Henry Straus	Secretary	Board Member
Jack Bierig	Director	Board Member
Richard Eggener	Director	Board Member
Linda Liss Fine	Director of Resident Services	Board Member
Marvin Rubin	Director of Administrative Services	Board Member
Cathy Wolfson	Director of Community Relations	Board Member
Hanna Goldschmidt	Director	Board Member
Richard Greenthal	Director	Board Member
M. Jay Heilbrunn	Director	Board Member
Suzanne Kach	Director	Board Member
Kurt B. Karmin	Director	Board Member
Martha Loewenthal	Director	Board Member
Margot Meyer	Director	Board Member
Stephen Nechtow	Director	Board Member
Henry Nord	Director	Board Member
Barbara Passman	Director	Board Member
Michael Ries	Director	Board Member
George Rosenbaum	Director	Board Member
Marianne Weinberg	Director	Board Member
Daniel Wolf	Director	Board Member
Judith Wolf	Director	Board Member

**See Accountants' Compilation Report**

Facility Name & ID Number Selfhelp Home of Chicago# 0018580 Report Period Beginning: 10/01/00 Ending: 9/30/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13				N/A					13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/01/00

Ending:

9/30/01

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8								N/A				8	
9	TOTAL Facility Related							\$	\$			\$	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related							\$	\$			\$	14
15	TOTALS (line 9+line14)							\$	\$			\$	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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9/30/01

**NOTES:**

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Selfhelp Home of Chicago COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0018580

CONTACT PERSON REGARDING THIS REPORT Mr. Marvin Rubin

TELEPHONE (773) 271-0300 FAX #: (773) 271-0633

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5. <u>                    </u>	<u>N/A</u>	\$ <u>                    </u>	\$ <u>                    </u>
6. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
<b>TOTALS</b>		\$ <u>                    </u>	\$ <u>                    </u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?            YES            NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73,944
 B. General Construction Type:
 Exterior
 Masonry
 Frame
 Steel
 Number of Stories 3

C. Does the Operating Entity?
 (a) Own the Facility
 (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (a) Own the Equipment
 (b) Rent equipment from a Related Organization.
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

The Selfhelp Home, Inc : retirement facility 94 apartments, square footage of 80,832

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	70,000	1970	\$ 191,769	1
2					2
3	TOTALS	70,000		\$ 191,769	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning:

10/01/00

Ending:

9/30/01

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	65	1974	1974	\$ 822,760	\$	50	\$ 16,455	\$ 16,455	\$ 436,063
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Security System	9/30/1980		786		15			786
10	Security System	9/30/1981		29,527		15			29,527
11	Building Improvements	9/30/1981		808		20	25	25	808
12	Building Improvements	9/30/1982		2,642		15			2,642
13	Building Improvements	9/30/1983		2,717		10			2,717
14	Building Improvements	9/30/1986		1,212		10			1,212
15	Building Improvements	9/30/1987		3,000		10			3,000
16	Building Improvements	9/30/1988		6,752		10			6,752
17	Building Improvements	9/30/1989		30,538		10			30,538
18	Building Improvements	9/30/1990		10,425		10			10,425
19	Building Improvements	9/30/1991		9,690		10	484	484	9,690
20	Building Improvements	9/30/1992		22,014		10	2,201	2,201	20,910
21	Building Improvements	9/30/1992		932		7			932
22	Building Improvements	9/30/1993		14,166		10	1,417	1,417	11,709
23	Building Improvements	9/30/1993		183		7			183
24	Building Improvements	9/30/1994		27,620		10	2,762	2,762	20,715
25	Building Improvements	9/30/1994		3,836		5			3,836
26	Building Improvements	9/30/1994		5,148		7	368	368	5,148
27	Building Improvements	9/30/1995		18,411		10	1,841	1,841	11,967
28	Building Improvements	9/30/1995		363		7	52	52	338
29	Building Improvements	9/30/1995		176,882	8,844	20	8,844		57,486
30	Building Improvements	9/30/1995		15,209		5			15,209
31	Building Improvements	9/30/1994		33,000		5			33,000
32	Fence	9/30/1996		6,704	202	20	336	134	1,680
33	Decorating	9/30/1996		5,905	136	20	294	158	1,176
34	Blacktop Resurfacing	9/30/1996		1,646	50	20	82	32	410
35	Security Camera	9/30/1996		895	26	20	44	18	220
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

**See Page 12A, Line 70 for total**

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Boiler repairs	9/30/1996	\$ 5,914	\$ 158	20	\$ 296	\$ 138	\$ 1,480		37
38	Emergency call system	9/30/1996	14,557	58	20	728	670	3,640		38
39	Cabinets & vanities	9/30/1997	2,938	34	20	147	113	717		39
40	Fire Alarms	9/30/1997	12,818	486	20	641	155	2,962		40
41	Elevator Improvements	9/30/1997	6,171	98	20	309	211	1,496		41
42	Ceiling	9/30/1997	563		20	28	28	140		42
43	Tubing and piping	9/30/1997	1,667	19	20	83	64	406		43
44	Faucets	9/30/1997	999		20	50	50	250		44
45	Flooring	9/30/1997	2,152	80	20	108	28	500		45
46	Air Conditioning	9/30/1997	1,505		20	75	75	375		46
47	Doors	9/30/1997	7,523	214	20	376	162	1,773		47
48	Cement Work	9/30/1997	1,275	32	20	64	32	304		48
49	Windows	9/30/1997	51,709		20	2,585	2,585	12,925		49
50	Outdoor Sprinklers	9/30/1997	2,573	64	20	129	65	612		50
51	Bathtub & Toilet	9/30/1997	605		20	30	30	150		51
52	Tuckpointing	9/30/1997	4,583		20	229	229	1,145		52
53	Blinds	9/30/1997	1,255	63	20	63		283		53
54	Boiler	9/30/1997	1,097		20	55	55	275		54
55	Office Refurbishing	9/30/1997	908	33	20	45	12	209		55
56	Compressor and Base Board	9/30/1997	680		20	34	34	170		56
57	Fire Alarms	9/30/1998	20,992	524	20	1,050	526	3,937		57
58	Sound System	9/30/1998	862		20	43	43	172		58
59	Architect	9/30/1998	43,360	2,112	20	2,168	56	7,615		59
60	Windows	9/30/1998	4,588		20	229	229	916		60
61	Lights	9/30/1998	1,517		20	76	76	304		61
62	Kitchen Sink	9/30/1998	1,230	62	20	62		217		62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,447,812	\$ 13,295		\$ 44,908	\$ 31,613	\$ 762,052		70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,447,812	\$ 13,295		\$ 44,908	\$ 31,613	\$ 762,052	1
2	Doors & Locks	9/30/1998	685		20	34	34	136	2
3	Audio/Visual System	9/30/1998	10,578	264	20	529	265	1,984	3
4	Wall/Windows	9/30/1998	2,222	62	20	111	49	413	4
5	Cabinets & Vanities	9/30/1998	1,300		20	65	65	260	5
6	Electrical Work	9/30/1998	11,441	284	20	572	288	2,146	6
7	Heating & Cooling	9/30/1998	9,470	236	20	474	238	1,777	7
8	Roof	9/30/1998	8,333		20	417	417	1,668	8
9	Floor Coverings	9/30/1998	3,067		20	153	153	612	9
10	Computer Wiring	9/30/1998	6,242	312	20	312		1,092	10
11	Handrails & Grab Bars	9/30/1998	6,020	301	20	301		1,054	11
12	Lights	9/30/1999	1,217		20	60	60	150	12
13	Floor Coverings	9/30/1999	4,564		20	228	228	570	13
14	Heating & Cooling	9/30/1999	1,373		20	68	68	170	14
15	Elevator	9/30/1999	37,272	194	20	1,864	1,670	4,660	15
16	Cabinets	9/30/1999	2,251		20	112	112	280	16
17	Wall	9/30/1999	2,790		20	140	140	350	17
18	Fire Alarm	9/30/1999	14,911	658	20	746	88	1,865	18
19	Roof	9/30/1999	35,283	160	20	1,597	1,437	4,076	19
20	Call/Paging System	9/30/1999	5,142	164	20	258	94	645	20
21	Pipes & Faucet	9/30/1999	865		20	44	44	110	21
22	Room Conversion	9/30/1999	3,169		20	158	158	395	22
23	Fire Ducts	9/30/1999	35,113	1,756	20	1,756		4,390	23
24	Security System	9/30/1999	13,503	676	20	676		1,690	24
25	Electrical Wiring	9/30/1999	20,805	1,040	20	1,040		2,600	25
26	Architect	9/30/1999	540	28	20	28		70	26
27	Blinds	2000	1,050		20	53	53	106	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,687,018	\$ 19,430		\$ 56,704	\$ 37,274	\$ 795,321	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,687,018	\$ 19,430		\$ 56,704	\$ 37,274	\$ 795,321	1
2	Cabinets	2000	3,135	23	20	134	111	268	2
3	Lobby Renovation	2000	3,397		20	170	170	340	3
4	Dining Room Renovation	2000	7,818	38	20	353	315	706	4
5	Washroom Renovation	2000	1,039		20	52	52	104	5
6	Light Fixtures	1999	893		20	45	45	90	6
7	Room Conversion	2000	673		20	34	34	68	7
8	Closet/Coat Room	2000	205		20	10	10	20	8
9	Doors	2000	1,568	5	20	73	68	146	9
10	Tiles	1999	140		20	7	7	14	10
11	Air Conditioner	2000	90		20	4	4	8	11
12	Resident Call System	2000	14,103	394	20	394		788	12
13	Heating & Cooling	2000	838		20	42	42	84	13
14	Ceiling Fan	1999	287		20	14	14	28	14
15	Dining Room Window	2001	1,834		20	46	46	46	15
16	Code Alert System	2001	2,501		20	62	62	62	16
17	Shower Temperature Control	2001	1,797	45	20	45		45	17
18	Call Station Living Room	2001	3,015	75	20	75		75	18
19	Doorknobs	2001	2,866		20	72	72	72	19
20	Repaving	2001	8,381		20	210	210	210	20
21	Fence	2001	784		20	20	20	20	21
22	Key Pad Locks	2001	776		20	19	19	19	22
23	Renovation of Kitchen, Basement & Elevator	2001	450,392	22,507	20	11,260	(11,247)	11,260	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,193,550	\$ 42,517		\$ 69,845	\$ 27,328	\$ 809,794	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 364,265	\$ 22,226	\$ 22,226	\$ (0)	5-7 years	\$ 194,308	71
72	Current Year Purchases	34,639	2,755	1,814	(941)	5-7 years	1,814	72
73	Fully Depreciated Assets	64,626				5-7 years	64,626	73
74								74
75	TOTALS	\$ 463,530	\$ 24,981	\$ 24,040	\$ (941)		\$ 260,748	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,848,849	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,498	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 93,885	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 26,387	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,070,542	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**1. Name of Party Holding Lease:** N/A

**2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?**

**If NO, see instructions.**

☐ YES      ☐ NO

**10. Effective dates of current rental agreement:**

## Beginning

## Ending

**11. Rent to be paid in future years under the current rental agreement:**

**8. List separately any amortization of lease expense included on page 4, line 34.**

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: \*

**15. Is Movable equipment rental included in building rental?**

**16. Rental Amount for movable equipment:** \$ N/A Description:

**(Attach a schedule detailing the breakdown of movable equipment)**

Fiscal Year Ending	Annual Rent
--------------------	-------------

12.                    /2002 §

13. \_\_\_\_\_/2003 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2004 \$ \_\_\_\_\_

**\* If there is an option to buy the building, please provide complete details on attached schedule.**

**\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.**

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs		N/A					7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12										
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 880,474	\$ 880,474	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 0 )	121,196	121,196	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,000	6,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	579,176	579,176	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,586,846	\$ 1,586,846	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		191,769	13
14	Buildings, at Historical Cost		822,760	14
15	Leasehold Improvements, at Historical Cost	1,068,498	1,370,790	15
16	Equipment, at Historical Cost	268,258	463,530	16
17	Accumulated Depreciation (book methods)	(381,377)	(1,070,542)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 955,379	\$ 1,778,307	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,542,225	\$ 3,365,153	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 30,855	\$ 30,855	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	29,306	29,306	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,242	2,242	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule 17A	67,359	67,359	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 129,762	\$ 129,762	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Attached Schedule 17A	85,492	85,492	43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 85,492	\$ 85,492	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 215,254	\$ 215,254	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 2,326,971	\$ 3,149,899	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,542,225	\$ 3,365,153	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.  
 PROVIDER # 0018580  
 September 30, 2001

**Schedule 17A**

**XV. BALANCE SHEET -**

<b>Other Current Assets (specify):</b>	<b>After</b>	
	<b>Operating</b>	<b>Consolidation</b>
Bequest Receivable	577,000	577,000
Scholarship Loan Receivable	7,950	7,950
Scholarship Loan Payable	(5,774)	(5,774)
<b>Total Line 9 - Other Current Assets (specify):</b>	<b>579,176</b>	<b>579,176</b>

<b>Other Current Liabilities (specify):</b>	<b>After</b>	
	<b>Operating</b>	<b>Consolidation</b>
Deferred Retirement Plan	34,173	34,173
Current Maturity Retirement Plan	6,000	6,000
Accrued Party Expense	27,186	27,186
<b>Total Line 36 - Other Current Liabilities (specify):</b>	<b>67,359</b>	<b>67,359</b>

<b>Other Long-Term Liabilities (specify):</b>	<b>After</b>	
	<b>Operating</b>	<b>Consolidation</b>
Interco A/C-Bonem Fund	27,336	27,336
Interco A/C-Scholarship	9,222	9,222
Interco A/C-Marx Fund	48,934	48,934
<b>Total Line 43 - Other Long-Term Liabilities (specify):</b>	<b>85,492</b>	<b>85,492</b>

See Accountants' Compilation Report

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 979,482	1
2	Restatements (describe):		2
3	Cumulative activity of funds other than healthcare facility	855,591	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,835,073	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	491,898	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 491,898	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,326,971	24 *

Operating entity only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning: 10/01/00

Ending:

Page 19

9/30/01

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,482,484	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,482,484	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	20,114	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,057	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 25,171	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	856,742	24
25	Interest and Other Investment Income***	29,692	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 886,434	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Guest Apartment</b>	1,275	28
28a	<b>Miscellaneous Income (Offset against expense)</b>	8,143	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,418	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,403,507	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	771,997	31
32	Health Care	1,307,608	32
33	General Administration	636,942	33
	<b>B. Capital Expense</b>		
34	Ownership	121,678	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	37,797	35
36	Provider Participation Fee	35,587	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,911,609	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	491,898	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 491,898	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.  
Tax Exempt Organization

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning: 10/01/00

Ending: 9/30/01

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,731	1,822	\$ 43,370	\$ 23.80	1
2	Assistant Director of Nursing	1,112	1,170	20,213	17.28	2
3	Registered Nurses	16,819	18,868	349,326	18.51	3
4	Licensed Practical Nurses	7,560	8,370	134,727	16.10	4
5	Nurse Aides & Orderlies	59,215	67,182	579,802	8.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,665	7,298	75,184	10.30	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,960	2,171	34,162	15.74	13
14	Head Cook	9,541	10,195	95,699	9.39	14
15	Cook Helpers/Assistants	19,546	20,190	121,569	6.02	15
16	Dishwashers					16
17	Maintenance Workers	3,496	3,680	50,607	13.75	17
18	Housekeepers	12,102	13,975	94,512	6.76	18
19	Laundry					19
20	Administrator	1,242	1,307	56,397	43.15	20
21	Assistant Administrator	1,608	1,648	41,015	24.89	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,577	9,572	154,349	16.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	303	303	7,186	23.72	33
34	TOTAL (lines 1 - 33)	151,477	167,751	\$ 1,858,118 *	\$ 11.08	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	276	\$ 11,060	L. 1, C. 3	35
36	Medical Director				36
37	Medical Records Consultant	48	1,920	L. 10, C. 3	37
38	Nurse Consultant	3	241	L. 10, C. 3	38
39	Pharmacist Consultant	Monthly	2,575	L. 10, C. 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,241	L. 11, C. 3	44
45	Social Service Consultant	30	1,674	L. 12, C. 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	399	\$ 19,711		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		N/A		52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number    **Selfhelp Home of Chicago**

**XIX. SUPPORT SCHEDULES**

STATE OF ILLINOIS

#    **0018580**

Report Period Beginning:    **10/01/00**

Page 21

Ending:    **9/30/01**

<b>A. Administrative Salaries</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 20%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Linda Liss Fine</td> <td>Administrator</td> <td>0%</td> <td style="text-align: right;">56,397</td> </tr> <tr> <td>Verna Segal</td> <td>Asst. Admin</td> <td>0%</td> <td style="text-align: right;">41,015</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ 97,412</td> </tr> </tbody> </table>				Name	Function	Ownership %	Amount	Linda Liss Fine	Administrator	0%	56,397	Verna Segal	Asst. Admin	0%	41,015																	TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 97,412	<b>D. Employee Benefits and Payroll Taxes</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Workers' Compensation Insurance</td> <td style="text-align: right;">\$ 37,485</td> </tr> <tr> <td>Unemployment Compensation Insurance</td> <td style="text-align: right;">5,100</td> </tr> <tr> <td>FICA Taxes</td> <td style="text-align: right;">141,839</td> </tr> <tr> <td>Employee Health Insurance</td> <td style="text-align: right;">122,672</td> </tr> <tr> <td>Employee Meals</td> <td> </td> </tr> <tr> <td>Illinois Municipal Retirement Fund (IMRF)*</td> <td> </td> </tr> <tr> <td>Retirement Plan</td> <td style="text-align: right;">2,524</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 22, col.8)</td> <td style="text-align: right;">\$ 309,620</td> </tr> </tbody> </table>				Description	Amount	Workers' Compensation Insurance	\$ 37,485	Unemployment Compensation Insurance	5,100	FICA Taxes	141,839	Employee Health Insurance	122,672	Employee Meals		Illinois Municipal Retirement Fund (IMRF)*		Retirement Plan	2,524											TOTAL (agree to Schedule V, line 22, col.8)	\$ 309,620	<b>F. Dues, Fees, Subscriptions and Promotions</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr> <td>IDPH License Fee</td> <td style="text-align: right;">\$  </td> </tr> <tr> <td>Advertising: Employee Recruitment</td> <td> </td> </tr> <tr> <td>Health Care Worker Background Check (Indicate # of checks performed <u>30</u>)</td> <td style="text-align: right;">360</td> </tr> <tr> <td>Life Services Network</td> <td style="text-align: right;">4,131</td> </tr> <tr> <td>Illinois Council on Long-Term Care</td> <td style="text-align: right;">2,623</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>Less: Public Relations Expense</td> <td style="text-align: right;">(  )</td> </tr> <tr> <td>Non-allowable advertising</td> <td style="text-align: right;">(  )</td> </tr> <tr> <td>Yellow page advertising</td> <td style="text-align: right;">(  )</td> </tr> <tr> <td>TOTAL (agree to Sch. V, line 20, col. 8)</td> <td style="text-align: right;">\$ 7,114</td> </tr> </tbody> </table>				Description	Amount	IDPH License Fee	\$	Advertising: Employee Recruitment		Health Care Worker Background Check (Indicate # of checks performed <u>30</u> )	360	Life Services Network	4,131	Illinois Council on Long-Term Care	2,623									Less: Public Relations Expense	(  )	Non-allowable advertising	(  )	Yellow page advertising	(  )	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,114
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\* Attach copy of IMRF notifications

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11						N/A							
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

<p><b>Facility Name &amp; ID Number</b>    <b>Selfhelp Home of Chicago</b></p> <p><b>XX. GENERAL INFORMATION:</b></p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union?    <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report?    <u>Yes</u>  If YES, give association name and amount.    <u>LSN \$4,131; IL Council \$2,623</u></p> <p>(3) Did the nursing home make political contributions or payments to a political organization?    <u>No</u>    If YES, have these costs been properly adjusted out of the cost report?    <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?    <u>No</u>    If YES, what is the capacity?    _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases?    <u>Yes</u>  What was the average life used for new equipment added during this period?    <u>6 Years</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.    \$ <u>34,934</u>    Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?    <u>Yes</u>    If NO, attach a complete explanation. _____</p> <p>(8) Are you presently operating under a sale and leaseback arrangement?    <u>No</u>  If YES, give effective date of lease.    <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement?    _____ YES <u>x</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?    YES _____ NO <u>x</u>    If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over  <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.    \$ <u>35,587</u>  This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?    <u>No</u>    If YES, attach an explanation of the allocation. _____</p>	<p style="text-align: center;"><b>STATE OF ILLINOIS</b></p> <p>#    <b>0018580</b>    Report Period Beginning:    <b>10/01/00</b>    Ending:    <b>9/30/01</b>    <span style="float: right;">Page 23</span></p> <hr/> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?    <u>N/A</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u>    For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V.    \$ <u>N/A</u>    Has any meal income been offset against related costs?    <u>Yes</u>    Indicate the amount.    \$ <u>5,057</u></p> <p>(16) Travel and Transportation  a. Are there costs included for out-of-state travel?    <u>No</u>  If YES, attach a complete explanation.  b. Do you have a separate contract with the Department to provide medical transportation for residents?    <u>No</u>    If YES, please indicate the amount of income earned from such a program during this reporting period.    \$ <u>N/A</u>  c. What percent of all travel expense relates to transportation of nurses and patients?    <u>0%</u>  d. Have vehicle usage logs been maintained?    <u>N/A</u>  e. Are all vehicles stored at the nursing home during the night and all other times when not in use?    <u>N/A</u>  f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?    <u>N/A</u>  <b>g. Does the facility transport residents to and from day training?</b>    <u>N/A</u>  <b>Indicate the amount of income earned from providing such transportation during this reporting period.</b>    \$ _____</p> <p>(17) Has an audit been performed by an independent certified public accounting firm?    <u>Yes</u>  Firm Name:    <u>Altschuler, Melvoin &amp; Glasser LLP</u>    The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?    <u>Yes</u>    If no, please explain.    <u>N/A</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?    <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?    <u>N/A</u>  Attach invoices and a summary of services for all architect and appraisal fees.</p>
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**SEE ACCOUNTANTS' COMPILATION REPORT**

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	251,430	0	11,060	262,490	0	262,490	0	262,490
2. Food P	0	193,835	0	193,835	0	193,835	-5,057	188,778
3. Housek	94,512	20,424	0	114,936	0	114,936	0	114,936
4	0	28,964	0	28,964	0	28,964	0	28,964
5. Heat ar	0	0	68,489	68,489	0	68,489	0	68,489
6. Mainte	50,607	0	52,676	103,283	0	103,283	38,904	142,187
7. *	0	0	0	0	0	0	0	0
8. Total G	396,549	243,223	132,225	771,997	0	771,997	33,847	805,844
9	0	0	0	0	0	0	0	0
10. Nursin	1,127,438	85,699	4,736	1,217,873	0	1,217,873	0	1,217,873
10a.	0	0	0	0	0	0	0	0
11. Activit	75,184	10,636	2,241	88,061	0	88,061	0	88,061
12	0	0	1,674	1,674	0	1,674	0	1,674
13	0	0	0	0	0	0	0	0
14	0	0	0	0	0	0	0	0
15. *	0	0	0	0	0	0	0	0
16. Total H	1,202,622	96,335	8,651	1,307,608	0	1,307,608	0	1,307,608
17. Admin	97,412	0	0	97,412	0	97,412	0	97,412
18	0	0	0	0	0	0	0	0
19. Profes	0	0	31,588	31,588	0	31,588	0	31,588
20. Fees,	0	0	7,114	7,114	0	7,114	0	7,114
21. Cleric	154,349	7,877	27,822	190,048	0	190,048	-8,143	181,905
22. Emplo	0	0	309,620	309,620	0	309,620	0	309,620
23	0	0	0	0	0	0	0	0
24. Travel	0	0	1,160	1,160	0	1,160	0	1,160
25	0	0	0	0	0	0	0	0
26. Insura	0	0	0	0	0	0	0	0
27. *	0	0	0	0	0	0	0	0
28. Total I	251,761	7,877	377,304	636,942	0	636,942	-8,143	628,799
29. Total J	1,850,932	347,435	518,180	2,716,547	0	2,716,547	25,704	2,742,251
30. Depre	0	0	67,498	67,498	0	67,498	26,387	93,885
31	0	0	0	0	0	0	0	0
32. Interes	0	0	0	0	0	0	0	0
33	0	0	0	0	0	0	0	0
34. Rent-f	0	0	54,180	54,180	0	54,180	-54,180	0
35	0	0	0	0	0	0	0	0
36	0	0	0	0	0	0	0	0
37. Total K	0	0	121,678	121,678	0	121,678	-27,793	93,885
38	0	0	0	0	0	0	0	0
39	0	0	0	0	0	0	0	0
40	0	0	0	0	0	0	0	0
41	0	258	0	258	0	258	0	258
42	0	0	35,587	35,587	0	35,587	0	35,587
43. Other	7,186	0	30,353	37,539	0	37,539	-37,539	0
44. Total L	7,186	258	65,940	73,384	0	73,384	-37,539	35,845
45. Grand	1,858,118	347,693	705,798	2,911,609	0	2,911,609	-39,628	2,871,981

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on	880,474	880,474
2. Cash - F	0	0
3. Account	121,196	121,196
4. Supply I	0	0
5. Short-T	0	0
6. Prepaid	0	0
7. Other Pi	6,000	6,000
8. Account	0	0
9. Other (s	579,176	579,176
10. Total c	1,586,846	1,586,846
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	191,769
14. Buildin	0	822,760
15. Lease	1,068,498	1,370,790
16. Equipn	268,258	463,530
17. Accum	-381,377	-1,070,542
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other I	0	0
23. other (:	0	0
24. Total L	955,379	1,778,307
25. Total A	2,542,225	3,365,153
CURRENT LIABILITIES		
26. Accour	30,855	30,855
27. Officer	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	29,306	29,306
31. Accrue	2,242	2,242
32. Accrue	0	0
33. Accrue	0	0
34. Deferre	0	0
35. Federa	0	0
36. Other (	67,359	67,359
37. Other (	0	0
38. Total C	129,762	129,762
LONG TERM LIABILITES		
39. Long-T	0	0
40. Mortga	0	0
41. Bonds I	0	0
42. Deferre	0	0
43. Other L	85,492	85,492
44. Other L	0	0
45. Total L	85,492	85,492
46. Total Li	215,254	215,254
47. Total E	2,326,971	3,149,899
48. Total Li	2,542,225	3,365,153

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,482,484
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	2,482,484
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Ancillary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	-
12. Gift and Coffee Shop	20,114
13. Barber and Beauty Care	0
14. Non-Patient Meals	5,057
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	25,171
24. Contributions	856,742
25. Interest and Other Investments Income	29,692
Subtotal - Non-Operating Revenue	886,434
27. Other Revenue (specify):	9,418
28. Other Revenue (specify):	0
Subtotal - Other Revenue	9,418
30. Total Revenue	3,403,507
31. General Services	771,997
32. Health Care	1,307,608
33. General Administration	636,942
34. Ownership	121,678
35. Special Cost Centers	37,797
35. Provider Participation Fee	35,587
37. Other	0
40. Total Expenses	2,911,609
41. Income Before Income Taxes	491,898
42. Income Taxes	0
43. Net Income or Loss for the Year	491,898

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

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19 The bottom right side of page under \*\*, you must write in any comments

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## RECONCILIATION REPORT

Selfhelp Home of Chicag

04:06 PM

11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-39,628	equal to	-39,628	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	93,885	equal to	93,885	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	0	equal to	0	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies		equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	771,997	equal to	771,997	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,307,608	equal to	1,307,608	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	636,942	equal to	636,942	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	121,678	equal to	121,678	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	37,797	equal to	37,797	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	35,587	equal to	35,587	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,127,438	equal to	1,127,438	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	75,184	equal to	75,184	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to		0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	251,430	equal to	251,430	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	50,607	equal to	50,607	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	94,512	equal to	94,512	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	97,412	equal to	97,412	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	154,349	equal to	154,349	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,858,118	equal to	1,858,118	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	11,060	< or = to	11,060	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	0	< or = to		0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,736	< or = to	4,736	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,241	< or = to	2,241	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,674	< or = to	1,674	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	97,412	equal to	97,412	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	31,588	equal to	31,588	-1	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	309,620	equal to	309,620	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	7,114	equal to	7,114	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,160	equal to	1,160	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	35,587	equal to	35,587	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	76,234	equal to	76,234	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	N/A	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	191,769	equal to	191,769	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,193,550	equal to	2,193,550	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	463,530	equal to	463,530	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,070,542	equal to	1,070,542	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,326,971	equal to	2,326,971	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	491,898	equal to	491,898	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,542,225	equal to	2,542,225	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1